TESTIMONY PRESENTED BEFORE THE EXECUTIVE AND LEGISLATIVE NOMINATIONS COMMITTEE

February 11, 2015

Joette Katz, Commissioner
Department of Children and Families

Senator Duff, Representative Janowski, Senator Kane, Representative Buck-Taylor, and members of the Executive and Legislative Nominations Committee, my name is Joette Katz and I thank you for this opportunity to talk about my priorities as Commissioner of the Department of Children and Families and about my professional experiences. It is a great honor to have been reappointed by Governor Malloy. Let me also thank each of you for your support these last four years and your commitment to continue the improvements that we together have made in how we serve Connecticut's children and families.

Certainly, we have a lot more work to do. We also, however, need to celebrate the significant progress our staff has made working together with the other professionals in the public and private sector and, most importantly, with the families and children themselves.

Much has been made of the fact that I resigned from the State Supreme Court to accept this position. Let me be clear. Serving as commissioner has been a great honor as it has allowed me to work with the men and women at the Department of Children and Families. The credit for the improvements we have witnessed belongs to our staff. Their tireless work and commitment in the face of considerable challenges are simply incredible. I am very, very proud of the workers at this agency. It is my honor to serve with them.

When Governor Malloy announced my appointment in late 2010, the Governor and I made public commitments to improve the Department's work. This reflected a consensus among both Connecticut advocates and national experts that Connecticut needed to:

- Reduce the number of children in state care;
- Place more children with relatives or other people the child knows;

- Reduce the number of children living in a group setting; and
- Reduce the number of children served out of state.

These goals required the Department to change its relationship with families to be more about cooperation and less about coercion. I quickly found out that no one wanted to change the relationship with families more than our staff. My job was to harness the energy of staff who wanted to work with families in a less adversarial and more engaging way. By capturing this energy, we quickly set out an agenda of reform: a Strengthening Families Practice Model, a Differential Response System, and child and family team meetings among other initiatives. All these reforms are grounded on the belief that child well-being is best served by strengthening and engaging families and service providers in identifying solutions. By working more respectfully with families and adopting a strengths-based approach that includes families at every step, the Department has made important progress.

As of January 1, 2015 and compared to January 2011:

- There are 866 fewer children in care -- a decrease of 18.1 percent;
- The percentage of children in care who live with a relative or someone else they know grew from 21% in January 2011 to 35.9%;
- The percentage of children in care who live in congregate (group) care dropped from 29.8% in January 2011 to 16.5% -- a reduction of 781 children or 54%; and
- There are 350 fewer children in out of state care -- a decrease of 96.7 percent. The number of children out of state stands at 12 as of January 1, 2015 compared to 362 when the administration began.

These are dramatic improvements, and our staff deserve the credit.

As proud as I am of our staff, I know we have much more work to improve in some critical areas.

CHILD DEATHS

One such area is child deaths -- an issue that tragically haunts every child welfare agency in the nation. While national research shows that it is difficult to predict child fatalities, we take very seriously our responsibility to learn as much as possible from both national and Connecticut experience and do everything we can to prevent them.

Accordingly, the Department just completed a study of 124 fatalities that occurred between January 1, 2005 and May 31, 2014 of children ages zero to three in families with some agency involvement. The study is prompting promising changes that will identify families with the highest risks and increase oversight and services for these families.

This "case-control" study found that Sudden Infant Death Syndrome was the most common cause of death (28.2%), followed by medical complications (12.1%), unsafe sleep (11.2%) and physical injury (8.1%). Consistent with previous Department reviews, unsafe sleep was found to be related to 33.9 percent of the deaths.

The study found the following statistically significant factors:

- The older the child is, the less likely the child will die. Among the 124 children who died, 65 percent were less than six months of age;
- Children who were high-risk newborns due to medical conditions were more likely to die;
- Fatalities were less likely when the Department conducted comprehensive assessments of the parents' needs;
- Fatalities were less likely when there were sufficient frequency of social worker visits with parents;
- Parents with mental health and substance abuse treatment needs were more likely to be involved in a child death; and
- Families with more child protection reports were more likely to suffer fatalities.

As we hoped, the study is prompting improvements. Later this year, the Department will deploy a "Rapid Safety Feedback" (RSF) system to identify families that require more oversight and services. The Department is entering an agreement with the Eckerd Foundation, a well-known private provider of social services that pioneered the Rapid Safety Feedback system in other jurisdictions. RSF uses both qualitative reviews and predictive analytics to identify child welfare-involved families who are at greater risk for a child fatality. Families with the highest risk factors will receive more social worker visits with the parents, more comprehensive assessment of parental needs, and more services to meet those needs. The effort will come at no expense to the State as Eckerd has identified philanthropic sources to fund the program's first year. Casey Family Programs will fund the second year.

This comes as the Department continues to address the largest single factor related to child deaths – unsafe sleep conditions for infants. Last year, the Department instituted a new policy requiring social workers to talk with parents of children under the age of one about safe sleep, to inspect the family's sleep arrangements, and to offer free "pack 'n plays" to families who need a safe place for the child to sleep.

The Department also has worked with hospitals and enhanced training of our staff and other professional staff to improve the recognition and identification of child abuse. Finally, the Department continues to work with national organizations, including Prevent Child Abuse America and Casey, as well as state partners, including the Office of the Child Advocate and other state agencies, to develop a public awareness campaign to educate families on preventing fatalities. The messages will focus on unsafe sleep conditions, abusive head trauma, also known as shaken baby syndrome, and targeted messaging to caregivers, especially men, on how to respond to a crying baby.

Through the implementation of these efforts, including the Eckard RSF tool and DCF's policy changes, and the public health campaign, DCF will evaluate the impact of these reforms on reducing fatalities so we focus our efforts on what works.

Even as we have made important progress in reducing the number of children in care, increasing the use of relatives and kin, and decreasing the use of group care and out of state care, we also have a clear responsibility to keep children safe.

That is why it is so important that we learn from these tragedies and that we take action to improve our work by educating our staff, the medical community, and families about preventing serious abuse and neglect that can result in a child's death.

The Department serves more than 34,000 families and 73,000 children in a year. But when it comes to child deaths, there is only one number that counts: one is too many.

We have a somber responsibility to respond to each child death, to ask ourselves hard questions about what could have been done differently, and to institute improvements from what we learn.

BEHAVIORAL HEALTH

Another major area of responsibility for the Department is reforming the children's behavioral health system. This is both an area of progress and an ongoing challenge. Beyond doubt, Connecticut is undergoing a major change in how we serve children with mental health and substance abuse treatment needs.

In the not-so-distant past, children who needed behavioral health services were almost always forced to leave their families, schools and communities. Connecticut now has significantly enhanced and expanded its capacity to get these children help without leaving behind everything they know and love. The numbers are dramatic: there are 781 fewer children in the care of the Department who are living in a group setting than in January 2011. That decline of 54 percent has allowed the state to reduce spending on group care by $70 million per year. As of January 22, 2015, 24 percent of slots in congregate care facilities were vacant.

The savings have been offset by $49 million in additional spending for services at home and in the community. The more restrictive levels of care are the most expensive, and therefore, dollar for dollar, more children can be served in the community than in a group setting. As important as being responsible with public funds, however, is that the children are far better served at home and in the community.

Best practice and national research have long held that treatment in institutional or group settings is only appropriate when used for those *individuals who absolutely need it and then only for the shortest time possible*. In other words, early intervention and treatment in the home and community are preferable for the vast majority of children. Ask any parent, a child should be living at home whenever possible.

Connecticut data shows children discharged from group care have done very well. Not only are the kids just as safe and just as likely to avoid re-entry into the foster care system, but 30 to 40 percent returned home with services

as needed. The majority of youth who remained in care did not experience a placement change within six months of leaving congregate care settings.

As with our other work, we have seen a lot of progress, AND there is a lot more work remaining. The Department recently submitted a plan to the Legislature to further reform the children's behavioral health system. Much of that plan calls for integrating behavioral health services into school and pediatric settings because the more we can make help accessible to families, the more likely they are to participate in services. The Department looks forward to working with lawmakers, sister state agencies and stakeholders to move that plan forward.

We expect and welcome a lot of stakeholder input. Some of the stakeholders say we are still too reliant on intensive levels of care; this includes advocates who are unhappy we have opened a small secure program in Middletown for girls who have been committed as delinquents. Other stakeholders are unhappy we are moving away from group settings for the vast majority of our kids. The goal is not to end all use of group settings; nor is it to go back to rely exclusively on group care. The goal is to have children be happy and successful living at home and in the community and to only have children away from those natural environments if it is absolutely necessary and for as short a time as possible.

OUT-OF-STATE PLACEMENTS

The Department has made tremendous strides in reducing the use of out-of-state care. As of January 1, 2015, the number of children out-of-state was 12 compared to the 362 children in January 2011, a decrease of 96.7%. This goes hand in hand with the overall reduction in the use of congregate care and the focus on using family homes or relative and kinship homes when out of home care is necessary.

I would add that five in-state providers have stepped up to design programs to serve those children with complex behavioral health needs requiring institutional level of care who previously had to go out of state to have their needs met. Because these children are now in Connecticut, they can more easily be part of their families, and their families can be part of their treatment.

JUVENILE JUSTICE

The Department has a unique and focused role in the larger juvenile justice system, which serves about 10,000 youths annually. Only 3 percent of those 10,000 are committed as delinquent to the Department after they repeatedly and unsuccessfully receive community based services from the Judicial Branch Court Support Services Division. The Judicial Branch's 97 percent success rate is spectacular and strongly supports the commitment that they and DCF has made to community-based services.

The courts specifically commit youths to the Department to receive a more intensive level of service involving residential or secure treatment. Nevertheless, the Department is committed to the principle that youths should be served in the community whenever possible and that a youth should be in a restricted setting only for as long as necessary.

Accordingly, we are pleased the census at CJTS is at its lowest since Raise the Age took full effect. As of February 1, 2015, there were only 88 boys at CJTS – down from a high of 151 in June 2014. We are hopeful this trend will continue and, for this reason and others, CJTS has instituted a new policy to more fairly manage lengths-of-stay. Lengths of stay will now be standard at six months, and boys who participate in treatment and other programming can have that reduced. The time can be increased for reasons related directly to safety, but only with the permission of the superintendent. A new policy on re-entry similarly will support a more standardized and fair process that will result in a lower census going forward. Finally, discharge planning to return youth to their communities now commences immediately upon entry.

With respect to our committed juvenile justice girls, there were only four girls in the Pueblo program on February 1, 2015.

It is important to recognize that we have this unique and relatively small role in the Connecticut juvenile justice system, which includes serving the highest need/highest risk youth who are committed to DCF by the courts. We have a responsibility to administer these services in the best way possible to ensure these youth can transition back to their communities successfully with positive goals and aspirations that we want all young people to have. To that end, we recently have brought in an outside, independent expert in meeting the therapeutic needs of youths to conduct a top-to-bottom evaluation of both CJTS and the Pueblo girls secure unit. Dr.

Robert Kinscherff, a clinical and forensic psychologist and an attorney, is a senior associate at the National Center for Mental Health and Juvenile Justice. The center's goal is to improve policies and programs for youth with mental health disorders who are involved with the juvenile justice system. He has written specifically about mental health treatment in juvenile justice programs, and he will bring enormous experience and expertise to our efforts to make CJTS and Pueblo model programs of therapeutic treatment and rehabilitation.

Connecticut is not unique in having secure program models for their juvenile justice population. While these programs are secure, we have and will continue to make strides in operating these facilities with the ultimate goal of rehabilitating youth and preparing them for a positive transition back to their communities as young adults. Education and clinical treatment are cornerstones of the programs' ability to successfully return youths back to their communities. Accordingly, we view restraints and seclusions as incidents to be avoided and to be used only when absolutely necessary to ensure safety. Without question, they are not therapeutic interventions and, while they are sometimes necessary for safety reasons when working with youths with very complex needs, we also know that they are the most common cause of injury for our staff. For these reasons, we conducted a two-day training for staff in December to support them in reducing the use of restraints. Staff are now engaged in the process of implementing the training into their daily work at both programs.

Our work with Dr. Kinscherff as well as Bill Carbone, whom you all know and respect as the former executive director of the Court Support Services Division of the Judicial Branch, and his team of experts from the University of New Haven will provide us with additional capacity to operate both CJTS and Pueblo as the therapeutic and educational programs that we want them to be.

Let me address directly one area of disagreement recently and that involves the CJTS Advisory Board. As you know, the Commissioner has the legal authority under CGS 17a-6(b) to appoint advisory boards for DCF institutions or facilities. In December, the CJTS advisory board was reconstituted so that its membership has a more diverse set of professional backgrounds and experiences. Only two members of the previous board were not re-appointed. These changes will in no way detract from the ongoing efforts to improve services at CJTS or reform how it conducts its

work. Many of the issues that the former advisory board leadership brought up are being addressed. No one on the previous advisory board was punished, and of course, no individual has a right to serve on any advisory board. We are confident that the new board will be more effective in providing feedback and constructive guidance to the facility and myself.

COURT MONITOR REPORTS

After nearly a quarter century, spanning four different Governors and six commissioners, the *Juan F.* Consent Decree remains a challenge. There is progress, however. Of the 22 outcome measures, the Court Monitor has pre-certified 11 measures – meaning that the Department has consistently met those standards. There is a regular schedule for the pre-certification of additional measures over the coming months.

The most challenging two outcome measures– case planning around treatment needs and needs met – are complicated by the fact that each measure contains 11 separate criteria that must be satisfied. For example, in the second quarter of 2014, the Department did not meet the "needs met" standard for only 13.6 percent of the individual criteria. Yet because all of the criteria must be met for a single case to be counted as "needs met," the Department's overall score was 59.3 percent. The way these two measures are carved into 11 different "mini-measures" – all of which must be met for that case to meet the standard – creates a very high bar.

Further, the methodology for these measures was established over a decade ago by a prior monitor and does not represent a complete picture of the work that is done. For example, in contrast to federal reviews, no interviews with staff, parents, children or service providers are conducted. The Monitors Office reviews a random selection of only 54 cases, which is not a statistically significant sample size.

In addition to methodological issues, the smaller number of children who remain in the child welfare system as a result of Differential Response and other reforms means that the children have more complex needs than in the past. Finally, because many of the needs are actually needs of the parents, the Department is reliant on the adult service system, which often lacks resources.

Despite all these challenges, there are DCF area offices that meet the standards for these two outcomes. Offices that are most challenged tend to be in urban areas where social problems related to poverty are most pronounced.

It must be noted too, however, that the Court Monitor reports also reflect a lot of success. For example, the most recent Court Monitor report said the Department "has made significant progress by instituting innovative directives and new protocols to re-shape the agency's approach to child welfare practice. Substantial changes have been made that address many of the core issues necessary to exit." The Court Monitor specifically cited child and family team meetings and the reduction of children in out of state care and in congregate care as important improvements as we strive to achieve permanent, lasting connections to families for all the children we serve.

CONCLUSION

Let me finish by emphasizing my appreciation to the many stakeholders in our work – starting with Governor Malloy, the Legislature, and the broad provider community. Special recognition must go to those who do the heavy lifting under difficult circumstances: the Department's staff and the families and children with whom they work together as partners.

Working together, all of us have made important progress these past four years. Broad reforms have taken effect – all based on the powerful principle that families have strengths and that, if we listen, families most often have the answers. This is the time to continue to press forward on this principle. I thank you for your support of this work, and I ask for your continued support as we still have much work to do.

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

DCF Service Array

CHANGES IN COMMUNITY-BASED AND CONGREGATE CARE SERVICES

SFY 11 – SFY 15

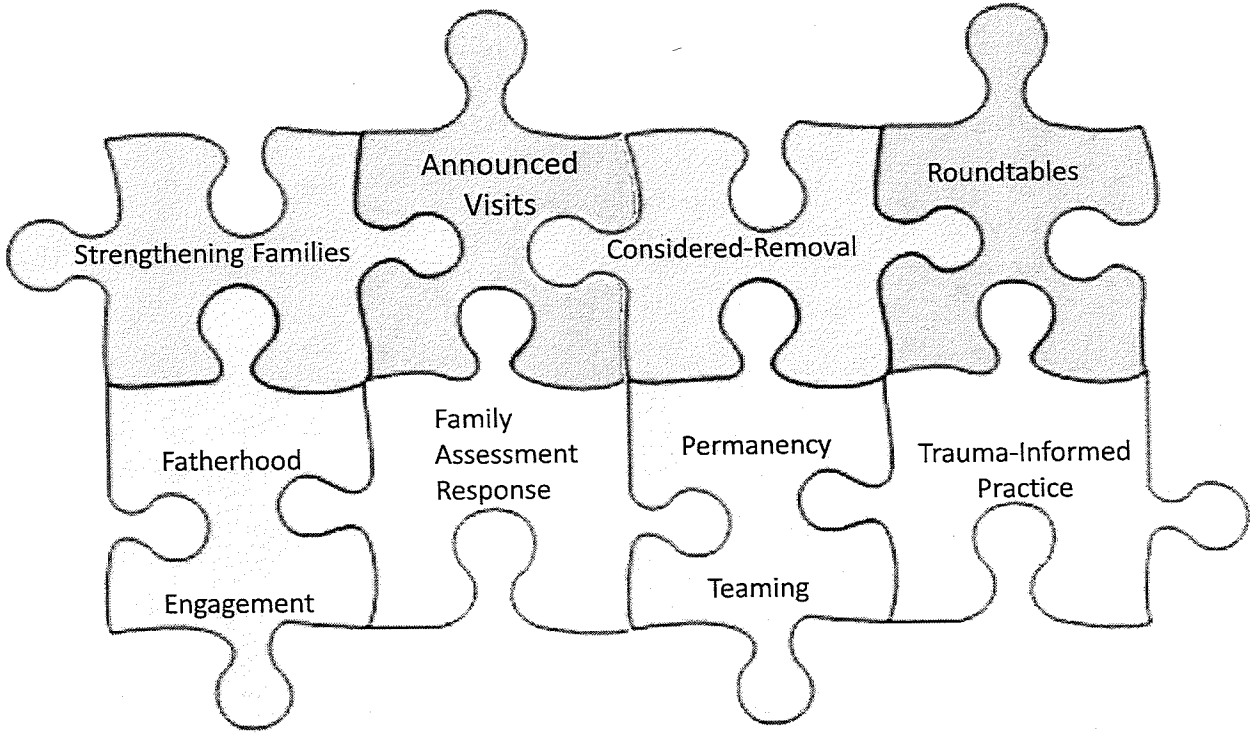
DCF Vision and Mission

The mission of the Department is to work together with families and communities for children who are healthy, safe, smart and strong.

Seven Cross-Cutting Themes

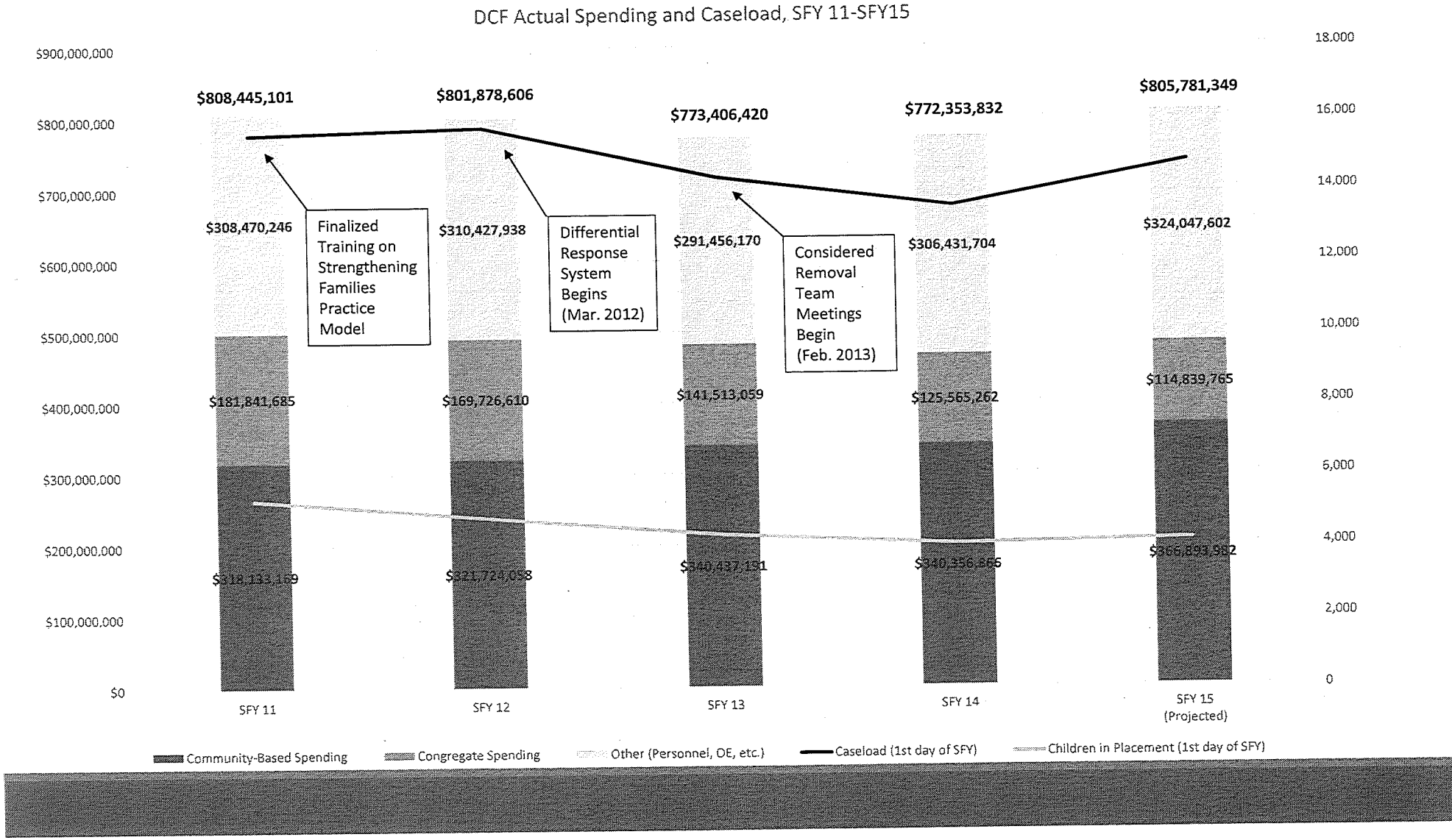
1. Implementing strength-based family policy, practice and programs.
2. Applying the neuroscience of early childhood and adolescent development.
3. Expanding trauma-informed practice and culture.
4. Addressing racial inequities in all areas of our practice.
5. Building new community and agency partnerships.
6. Improving leadership, management, supervision and accountability.
7. Becoming a learning organization.

Practice Transformations



System Transformations

- Fostering the Future – Foster care re-design
- Relative Placement
- Supports for Relative Caregivers
- Family and Community Ties Program
- Investment in Community-based services
- Wendy's Wonderful Kids
- Congregate Rightsizing


DCF Actual Spending and Caseload, SFY 11-SFY15
$900,000,000
$800,000,000
$700,000,000
$600,000,000
$500,000,000
$400,000,000
$300,000,000
$200,000,000
$100,000,000
$0
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
$808,445,101
$801,878,606
$773,406,420
$772,353,832
$805,781,349
$308,470,246
$310,427,938
$291,456,170
$306,431,704
$324,047,602
$181,841,685
$169,726,610
$141,513,059
$125,565,262
$114,839,765
$218,133,169
$321,724,058
$340,437,131
$340,356,866
$366,893,982
Finalized Training on Strengthening Families Practice Model
Differential Response System Begins (Mar. 2012)
Considered Removal Team Meetings Begin (Feb. 2013)
SFY 11
SFY 12
SFY 13
SFY 14
SFY 15 (Projected)
Community-Based Spending
Congregate Spending
Other (Personnel, OE, etc.)
Caseload (1st day of SFY)
Children in Placement (1st day of SFY)

SFY 11 Actual Spending

- **Reductions ($11,950,959)**
  - $274,500 from the elimination of the Hartford Youth Project (ABH)
  - $1,933,104 from the elimination of Enhanced Care Coordination
  - $2,924,676 reduced by closing 3 Group Homes
  - $2,513,805 reduced by closing 2 Permanency Diagnostic Centers
  - $1,373,334 reduced by closing 1 Short-Term Residential
  - $2,931,540 reduced by closing 3 Safe Homes
- **Additions / Increases ($14,210,551)**
  - $432,864 for Residential Transitioning Services
  - $5,200,000 for Supportive Housing
  - $3,980,678 additional spending in Board & Care – Adoption
  - $4,597,009 additional spending in Board & Care – Foster Care

SFY 12 Actual Spending

- **Reductions ($12,509,963)**
  - $619,228 reduction in IICAPS
  - $1,520,947 reduction in spending in Board & Care – Foster Care
  - $1,112,183 reduction in spending for Individualized Family Supports
  - $949,415 reduced by closing 1 Group Home
  - $8,308,190 less paid to Residential Treatment Centers because of fewer placements
- **Additions / Increases ($2,367,732)**
  - $541,378 for Supportive Housing
  - $240,000 for MDFT
  - $1,586,354 additional spending in Board & Care – Adoption

SFY 13 Actual Spending

- **Reductions ($33,637,353)**
  - $17,266,577 less paid to Residential Treatment Centers because of fewer placements
  - $8,726,885 reduced by closing 9 Group Homes
  - $7,643,891 reduced by closing 7 Safe Homes

- **Additions / Increases ($16,612,171)**
  - $2,268,000 for Supportive Housing
  - $4,000,000 for Differential Response
  - $5,774,874 additional spending in Board & Care – Adoption
  - $4,569,297 additional spending in Board & Care – Foster Care

SFY 14 Actual Spending

- **Reductions ($20,429,778)**
  - $1,809,876 reduction in spending in Board & Care – Adoption
  - $6,736,835 reduction in spending in Board & Care – Foster Care due to fewer children in care
  - $4,541,817 reduction in spending for Individualized Family Supports
  - $11,883,067 less paid to Residential Treatment Centers because of fewer placements

SFY 14 Actual Spending

- **Additions / Increases** ($14,571,470)
  - $5,250,000 for Differential Response
  - $1,810,000 for ACCESS-Mental Health
  - $1,000,000 for MATCH-ADTC
  - $500,000 for TFCBT – Bridgeport Public Schools
  - $1,000,000 for TFCBT – South-central Public Schools
  - $1,000,000 for Trauma Focused CBT
  - $1,217,546 for Intensive Home Based Services: Family-Based Recovery
  - $110,282 for Emergency Mobile Psychiatric Services enhancement
  - $1,584,620 for MST – Building Stronger Families
  - $277,104 for MST – Problem Sexual Behaviors
  - $821,918 for a Congregate Care Reduction Management Entity

SFY 15 Actual Spending (Projected)

- **Reductions ($12,574,620)**
  - $1,803,868 reduction in spending for Individualized Family Supports
  - $5,939,202 reduced by closing 6 Group Homes
  - $4,831,550 less paid to Residential Treatment Centers because of fewer placements

- **Additions / Increases ($9,949,561)**
  - $1,000,000 for Homeless Youth
  - $2,000,000 for a Congregate Care Reduction Management Entity
  - $3,023,265 additional spending in Board & Care – Adoption
  - $3,926,296 additional spending in Board & Care – Foster Care

SFY 15 Compared to SFY 11

- $58,942,899 more spending in community-based services
- $75,292,132 less spending in congregate care

$.79 of every dollar saved in congregate care has been reinvested in community-based services

- 32 fewer congregate settings
- 820 fewer congregate beds being used (in-state and out-of-state)
- 12% reduction in DCF caseload
- 18% reduction in the number of children in placement
- 70% increase in the percentage of children placed with relatives and kin
- 97% reduction in the number of children placed in out-of-state congregate care settings
- 84% of children in placement are living with a family, compared to 70% in 2011

Child Outcomes for 2014

Child Safety & Stability

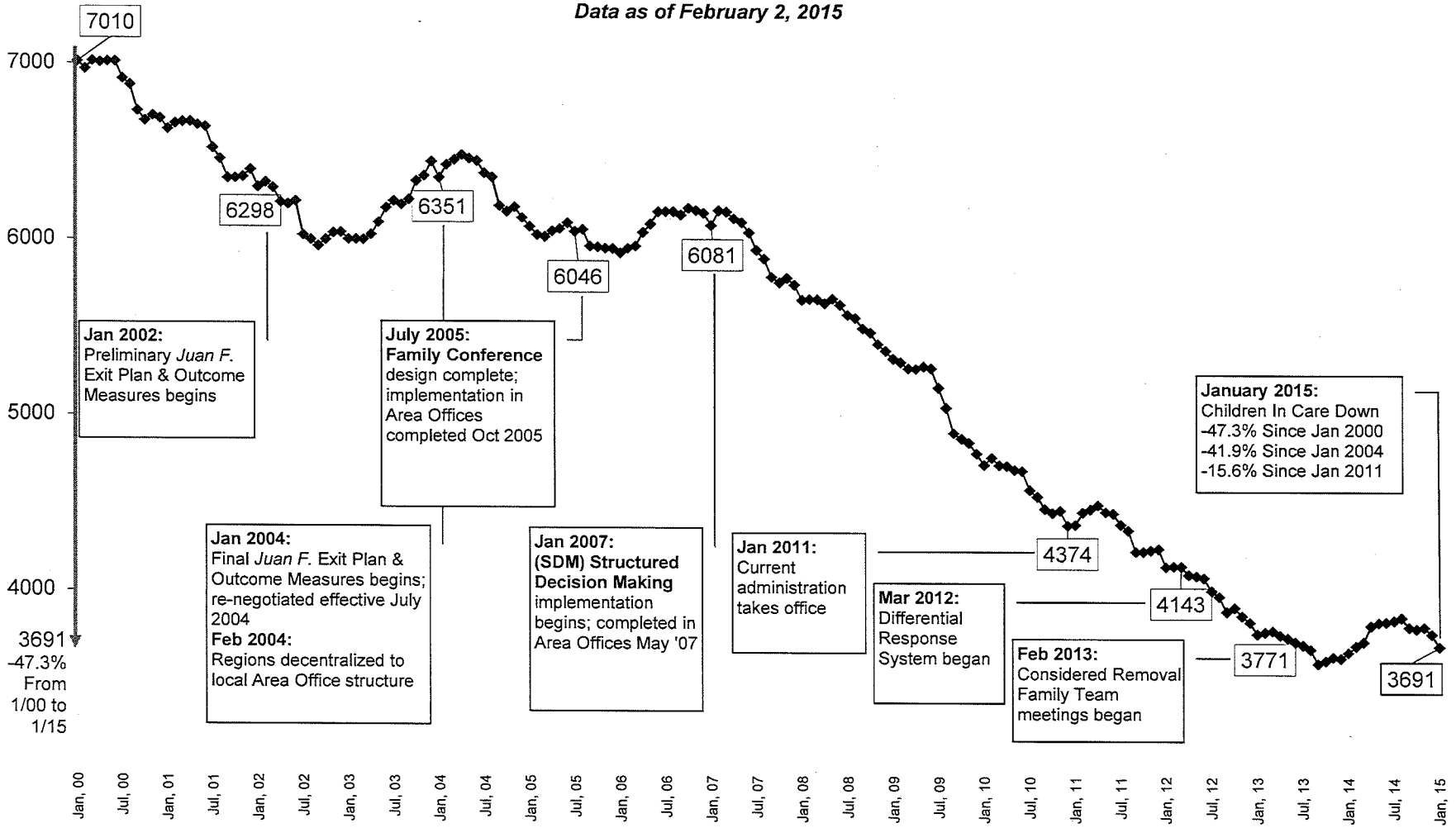
- 95.4% of children in in-home cases were not victims of repeat maltreatment
- 99.7% of children in foster care were not victims of repeat maltreatment
- 94% of children entering care did not have a foster care episode in the previous 12 months
- 96% of children in foster care did not experience multiple placements

Permanency & Well-Being

- 68% of reunifications in 2014 happened within 12 months (exceeding Juan F. standard)
- 34% of adoptions in 2014 happened within 24 months (exceeding Juan F. standard)
- 72% of transfers of guardianship happened within 24 months (exceeding Juan F. standard)

Number of Juan F. Children* in DCF Placement On First Day of Each Month
January 2000 - January 2015

CT DCF Office for Research and Evaluation
Data as of February 2, 2015



**** Includes all Juan F. children in open DCF placements on the first day of each month; Excludes Committed Delinquent, Voluntary, Probate and Interstate Compac. On any given day DCF is responsible for an average of 5.7% additional children who have left open placement, but for which DCF is still legally responsible.***